UTILIZATION REVIEW REPORT

INTRODUCTION

Under the provisions of the Multipurpose Senior Services Program's (MSSP) Home- and Community-Based Services (HCBS) Waiver and the State Medicaid Plan, the program is required to establish and maintain a system of Utilization Review (UR). The authority to conduct these reviews is found in the following sources:

Federal – Title XIX, Social Security Act, Section 1915 I; 42 Code of Federal Regulations (CFR), Section 456; Federal Home- and Community-Based Services Waiver.

State – Welfare and Institutions (W&I) Code, Section 14170; Title 22 California Code of Regulations, Title XXII, Section 51346; Interagency Agreement #01-15976 between Department of Health Care Services (DHCS) and California Department of Aging (CDA) and CDA policies.

The CDA conducts collaborative and independent URs to monitor the program at the site level for compliance with the Waiver, the Interagency Agreement (IA) between CDA and DHCS, and CDA MSSP policies. Currently, each site is scheduled to be reviewed every other year. The objectives of the CDA UR process are to:

1. Verify the medical necessity of services provided to eligible MSSP clients funded by the HCBS Waiver.

2. Ensure that available resources and services are being used efficiently and effectively.

3. Identify problem areas and to provide technical assistance (TA) as needed.

4. Initiate corrective action(s), if warranted.

The process followed by the CDA UR team involves a review of pertinent documentation, procedures and processes; consultation and discussion with staff; and a home visit to a client. The specific areas addressed by this report are:

1. NECESSITY OF SERVICES: Client Eligibility and Level of Care (LOC).

2. CLIENT ENROLLMENT, RIGHTS, AND INFORMATION: Application, Client Enrollment /Termination Information Form (CETIF), Notification of Rights, Authorization for Use and Disclosure of Protected Health Information Form (AUDPHI), Institutionalization Form (IF).

3. APPROPRIATENESS OF SERVICES: Initial Health Assessment (IHA), Initial Psychosocial Assessment, Reassessment (IPSA), Care Plan, Assessing and Documenting Client Risk, Progress Notes, and Case Record.

4. AUTHORIZATION AND UTILIZATION OF SERVICES: Service Planning and Utilization Summary (SPUS), Tracking Cost Effectiveness, and Vendor Agreement Review.

5. QUALITY ASSURANCE ACTIVITIES: Peer/Internal Review, Client Satisfaction Survey and Home Visit.

METHODOLOGY

Review Date:	June 21, 2010 through June 23, 2010
Review Site:	Partners in Care Foundation-South Multipurpose Senior Services Program-43 675 South Carondelet Street Los Angeles, California 90057-3309
Record Review:	Twenty records, of which six were terminated
Review Period:	November 2008 through December 2009
CDA-MSSP Review Team:	Francie Posey, Nurse Evaluator II Jennifer Luna-Friedrich, Program Analyst II Susan Rodrigues, Program Analyst II
Scheduled Conferences:	Entrance: June 21, 2010; Exit: June 23, 2010
Conference Participants:	Anwar Zoueihid, Vice President of Direct Services Aloyce Rachal, Site Director Renee Ochoa, Supervisor Care Manager (SCM) Pamela Mitchell, Fiscal Manager Maria Acuna-Cantu, Nurse Care Manager (NCM) LeNay Maull, Social Worker Care Manager (SWCM) Fannie Gurrola, SWCM Gretchen Washington, SWCM Andrew Nuygen, SWCM Betty McNeill, Admin/Clerical

DEFINITION OF TERMS

1. Findings:
   - Conclusions reached after the UR. Documents site practices during the review period. Compares what exists at the site with what is required.

2. Recommendations:
   - Actions necessary to correct existing conditions or improve operations and practices. The recommendations indicated in this report are requirements not suggestions.

3. Technical Assistance:
   - Documents information provided to site staff during UR. Includes consultation on specific client cases, printed information, online resources, policy references, etc. TA may also document subsequent research and responses provided to site staff following the UR.

4. Corrective Action:
   - Remediates problems found in site practices and ensures compliance to MSSP policies including the federal Waiver and the current Contract. A Corrective Action Plan (CAP) includes but is not limited to the following:

     - Revision of the site's existing procedures and practices or development of new ones. The site shall submit written documentation describing these changes.

     - Training of site staff necessary to implement the required CAP. Training documentation to be submitted to CDA may include, but is not limited to, the following:
       - Schedule of in-service sessions and dates;
       - Sign-up sheet or roster of session attendees;
       - Agenda or syllabi of sessions (topics covered);
       - Name of person(s) conducting the sessions;
       - Session hand-outs; and
       - Synopses of session results including specific problem areas addressed.

     - Periodic submittals to CDA, which may include examples of redacted case record documents, such as care plans, assessment forms, progress notes, etc., produced following the required training and remediation.

CORRECTIVE ACTION PLAN

A CAP is required as specified in the following UR Findings. A CAP is required to ensure compliance with the listed findings and recommendations. Please submit to CDA within 30 days. Regarding the CAP for care plans, the site is to submit one care plan written by each care manager (CM) authored after June 23, 2010, along with the pertinent assessment/reassessment summary with functional grids, to CDA by September 1, 2010.

CDA reviewers may attend scheduled in-service training sessions developed in conjunction with the CAP without notice.

I. NECESSITY OF SERVICES

The objective of the MSSP is to avoid, delay, or remedy the inappropriate placement of persons in nursing facilities, while fostering independent living in the community. At a cost lower than nursing facility placement, MSSP provides services to eligible clients and their families to enable clients to remain in or return to their homes. Case record documentation must support the client's need for these services.

Reference: MSSP Site Manual

I. A. Client Eligibility

Eligibility for the program is addressed initially at screening and confirmed throughout participation in the program. MSSP eligibility criteria include all of the following:

- Age 65 or older;
- Residence in the catchment area;
- Receiving Medi-Cal under an appropriate code;
- Certifiable for placement in a nursing facility (refer to the LOC section of this report for criteria requirements);
- Ability to be served within the cost limitations of MSSP, and
- Appropriate for care management services.

Reference: MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

I. B. Level of Care

The LOC determination is a clinical judgment made by the NCM. The LOC is a timely analysis of information gathered to determine and verify that the client is certifiable for placement in an Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF). The body of the client's case record must support the LOC determination.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

Five client records (#XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained LOCs that did not fully describe clients' functional deficits and with which ADLs/IADLs they needed assistance.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.110.3. Areas to describe include:

- Cognition/sensory deficits;
- ADLS:
  - Eating
  - Dressing
  - Transferring
  - Bathing
  - Toileting
  - Grooming;
- IADLs:
  - Medications
  - Stair Climbing
  - Mobility Indoors
  - Mobility Outdoors
  - Housework
  - Laundry
  - Shopping/Errands
  - Meal Preparation/Cleanup
  - Transportation
  - Telephone
  - Money Management;
- Other pertinent factors e.g., environment.

Corrective Action:

Although the number of findings constituted a trend, as CDA conducted LOC training in May and June 2010 just prior to this review, there will not be a CAP at this time. CDA plans to conduct a follow-up visit approximately six months from the date of this report. Depending upon the outcome of that follow-up review, CDA may require a CAP at that time.

II. CLIENT ENROLLMENT, RIGHTS AND INFORMATION

II. A. Application

The application form is the vehicle for applying for services and summarizes what a client can expect from MSSP, alternatives regarding services and the rights of program participants. The application must be completed prior to conducting the LOC determination, and a copy of the application must be provided to the client.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

II. B. Client Enrollment/Termination Information Form

The CETIF records client demographic information. Data fields must be complete and accurate. As data is changed or updated, a new hard copy must be printed and filed chronologically in the record.

References: MSSP Site Manual and MSSP Contract.

Findings:

Seven terminated client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained forms that were missing the last two digits of the year clients were terminated from the program.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP site Manual Section 7.210 that states, “The bottom of the form (below the double lines) is completed at the time a client’s participation in MSSP is terminated. Once the data has been entered into the computer system, a hard copy of the form is printed out and filed chronologically in the client’s case record.”

Corrective Action:

The site is working with its software vendor to resolve this issue; therefore, a CAP is not required.

II. C. Notification of Rights

MSSP sites must inform clients and/or their designees of their right to be informed of MSSP components which are material to a client's participation (or lack of participation) in the MSSP. Program components include:

1. Processes on registering complaints, termination and appeal;

2. The safeguarding of client information (including application, Care Plan and termination form) through proper use of the AUDPHI Form and storage of client records;

3. Services that may be provided by MSSP as well as alternatives to participation in the program;

4. Potential outcomes of refusing offered services; and

5. Client participation in MSSP care planning and service satisfaction surveys.

Notices of Action (Termination and Change):

- State law and Medi-Cal regulations require that a Notice of Action (NOA) be sent to an applicant who is denied eligibility at point of application or to a MSSP client who has a change in service or who is terminated (for codes specified in the Site Manual) from the program. Timeframes for mailing NOAs are specified in the Site Manual. The NOA informs the applicant/client of rights to a fair hearing if they are dissatisfied with the termination action, change in services, or denial of entry into the MSSP. A copy of the NOA will be filed in the client's case record.

Client Rights/Right to State Hearing:

- Clients will be informed in writing and in a timely manner of their right to request a State Medi-Cal hearing when they indicate disagreement with any decision, which would result in a discontinuance, termination, suspension, cancellation or decrease of services under the program.

Reference: MSSP Site Manual and California Welfare and Institutions Code

Findings:

Client Record #XXXX contained documentation that the client was terminated due to XXXX XXXX (reason code XX). A NOA was not mailed to the client's XXXX XXXX XXXX.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.1720 Notice Of Action that states,
"State law and Medi-Cal regulations require that a Notice of Action (NOA) is sent to an applicant who is denied eligibility at point of application (Appendix 2) or for an adverse decision regarding a reduction, suspension, termination or denial of waiver services (Appendix 4), or to an MSSP client who is terminated from the program for the following reason codes: 2, 3, 4, 5, 7, 8, 9 or 10 (Appendix 2)."

The termination NOA must be mailed to the client's last known address.

Corrective Action:

One finding did not constitute a trend; therefore, a CAP is not required.

II. D. Authorization for Use and Disclosure of Protected Health Information Form

MSSP sites must comply with contract requirements regarding client confidentiality. Sharing and obtaining information requires specific client consent as provided in the AUDPHI. This form must:

- Address only one individual or agency;
- Be specific as to the particular information (such as diagnosis, treatment, or financial information) that is requested from/to that entity; and
- Include an expiration date which cannot exceed two years from the date of the client's signature.

References: MSSP Site Manual and MSSP Contract

Findings:

Eleven client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) did not contain AUDPHIs for family members and/or caregivers as required. Client Record #XXXX did not contain any AUDPHIs.

Recommendations:

Conduct a training session within 60 days from the date of this report. Submit to CDA the name of the person conducting the training session, curriculum used, and a list of attendees.

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.520 Authorization For Use And Disclosure Of Protected Health Information Form that states, "All pertinent data will be entered on the form (Appendix 14) before the client is asked to sign. Staff will not have clients sign blank forms (e.g., with the intent of staff filling in necessary information on an "as needed" basis at a later date). More than one authorization may be obtained, but each **must** specifically state the agency or individual who is to provide or receive the information, and the type of information to be exchanged.

Corrective Action:

The number of findings constituted a trend; therefore, a CAP is required.

II. E. Institutionalization Form

Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits are to be recorded on the IF. MSSP sites are responsible for the inclusion of the IF in the client case record. The IF provides a chronology of the client's hospitalizations and admitting diagnoses.

Reference: MSSP Site Manual

Findings:

Ten client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained IFs that did not include all episodes of either XXXX visits, XXXX, or XXXX admissions.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.1205 Institutionalization Form that states, "Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits **must** be recorded on the Institutionalization Form (Appendix 23). This form consolidates information regarding institutionalizations to identify health issues related to the client's need for care management

Corrective Action:

Although the number of findings constituted a trend, the site indicated they would correct their practices. Therefore, a CAP is not required.

III. APPROPRIATENESS OF SERVICES

The criteria for Appropriateness of Services address the client's need for and ability and willingness to participate in the care management process. Both elements must be present.

- "Need for care management" is indicated when a client requires assistance to: gain access to community services (whatever the funding source); maintain or effectively utilize available services; or manage serious health conditions.

- "Ability and willingness to participate" is indicated by the client's cooperation in formulating and then carrying out the Care Plan. The term "client" includes a client's significant support person when the client is cognitively unable to participate independently.

It is important to confirm and document a new client's perception of why they were referred to the program, and how they characterize their situation, needs and goals. This would logically occur during either the screening or the assessment process. Differences in perceptions between the referral source, the client and the CM must be identified, acknowledged and addressed in the initial assessments.

References: MSSP Site Manual and MSSP Contract

III. A. Initial Health Assessment, Initial Psychosocial Assessment, and Reassessment

Assessment is the foundation of the care management process. Each person determined to be eligible through the MSSP intake screening process will receive face-to-face comprehensive IHA and IPSAs to determine specific problems, resources, strengths, needs and preferences and to confirm LOC.

Reassessment is a formalized method of documenting and analyzing changes during the period since the previous assessment, re-establishing eligibility as it relates to LOC and assuring that the client's needs are being met. Changes since the last assessment, as well as over a longer span of time, are particularly relevant.

Assessment instruments and forms include but are not limited to:

- IHA and IPSA
- Reassessments
- Summaries and Problem Lists
- Client's Medication List
- Client's Physicians and Other Health Professionals
- Initial Psychosocial Functioning
- CDA-Approved Cognitive Evaluation
- FNAG

References: MSSP Site Manual and MSSP Contract

Findings:

Client Record #XXXX contained a medication list that did not include XXXX.

Client Record #XXXX did not include problem lists with the IHA and IPSA.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.620 Assessment/Initial Assessments that states, "The documents used are required by CDA (Appendices 18 and 19) and consist of the assessment (initial health and psychosocial) and supporting forms (e.g., CDA approved cognitive screening tools, Medication list).

The documents required by CDA consist of:

Initial Health Assessment (Appendix 18)

- Cover Sheet
- Body of the Assessment
- Physicians and Other Health Professionals List
- Medication List
- Problem List
- IHA Summary

Initial Psychosocial Assessment (Appendix 19)

- Cover Sheet
- Body of the Assessment
- Psychological Functioning
- CDA approved cognitive screening tool
- FNAG
- Problem List
- IPSA Summary

(Assessment/reassessment forms must contain a summary which also includes a problem list of issues/concerns that will be formulated into problem statements on the care plan.)

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

III. B. Care Plan

Care planning is the process of developing an agreement between the client and CM regarding identified client problems and resources, outcomes to be achieved and services to be pursued in support of goal achievement. The Care Plan must reflect services and supports necessary to sustain the client's ability to live in their community. The Care Plan provides a focus for the needs identified in the functional assessments, organizes the service delivery system to the client and helps to assure that the service being delivered is appropriate to the client's needs/problem.

The MSSP interdisciplinary care management team will develop a client-centered written comprehensive Care Plan for each client. It will be based on IHA and IPSA or reassessment findings, reflect all appropriate client needs, encompass both formal and informal services and will be written within two weeks of the latest assessment or reassessment.

The MSSP Care Plan includes:

- Statements of problems and needs determined upon assessment;
- Strategies to address the problems and needs; and
- Measurable goals or outcomes used to demonstrate resolution based upon the problem and need, the time frame, the resources available, and the desires and the motivation of the client and/or family.

References: MSSP Site Manual and MSSP Contract

Findings:

Effective dates for care plans were listed as the date of the care conference instead of the client's enrollment month and year.

Seven client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained care plans with late client signatures or no client signatures.

Fifteen client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained problem statements with interventions or stated only the client's medical diagnoses.

Three client records (#XXXX, #XXXX, and #XXXX) contained problem statements that were not client-centered e.g., "The client's XXXX is at risk for XXXX."

Eleven client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained interventions that did not fully address the clients' problems or were item-centered. For example, XXXX was listed as the only intervention to address XXXX.

Nine client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained goals that were not measurable and/or contained interventions within goals.

Two client records (#XXXX and #XXXX) contained NOAs that were sent to clients to add problems to the care plan that were not listed on the care plan. Items purchased with waiver funds but not listed on care plans can be subject to recovery.

Client Record #XXXX contained documentation that the client had been discharged from the hospital with a XXXX for which XXX received home health nursing services. This problem was not added to the client's care plan.

Client Record #XXXX contained documentation that the client needed a XXXX XXXX in XXX XXXX that was provided XX months after identification of the need. The client did have a XXXX in the XXXX outside XXXXXXX.

Client Record #XXXX listed "XXXX – XXXX as needed" instead of specifically listing XXXX, XXXX, XXXX, XXXX, and XXXX that were purchased for the client.

Client Record #XXXX contained documentation that waiver funds were used to purchase XXXX XXXX. The site purchased a XXXX for the client that was not included on the care plan. The waiver funds spent on these items can be subject to recovery.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.640.3 Care Plan Components that explains how to develop problem statements, measurable goals, and interventions.

When a new client need arises, evaluate the current problems on the care plan to determine whether proposed interventions could help address an existing problem. Every new intervention does not warrant its own problem. Similar issues can be combined into the same problem statement.

Suggested Problem Statements and Goals:

1. Problem Statement:
    - The client is at risk for falls due to history of experiencing one fall per month and weakness secondary to right-sided cardio-vascular accident (CVA).

    Goal:
    - The client will report no injury from falls over the next year as confirmed during monthly contacts.

Interventions: Purchase emergency response system (ERS)
Provide bathroom safety equipment – specify – handheld shower (HHS), grab bars, non-slip bath mat, rugs
Obtain ramp
Obtain lift chair (with MD prescription)
Perform Fall Risk Assessment (Appendix 21g)
Coordinate PT/OT consult (with prescription)

2. Problem Statement:
   - The client is at risk for gaps in care due to high level of need due to debilitated condition resulting in daughter caregiver's burnout.

   Goal:
   - The client will experience zero gaps in care during the next 12 months to be monitored during monthly contacts.

   Interventions: Provide respite for caregiver daughter up to 8 hours/month
   Coordinate schedules for church and other family members to visit client
   Advocate for increased IHSS hours

3. Problem Statement:
   - The client is at risk for skin breakdown related to urinary incontinence.

   Goal:
   - The client/caregiver will report intact skin during the next 12 months to be monitored during monthly contacts.

   Interventions: Coordinate incontinence supplies (TAR)
   Purchase wipes, gloves, creams
   Purchase sheets, towels
   Purchase new bed mattress
   Coordinate wound care via home health agency
   Contact client's primary doctor to provide referral for urology consult

4. Problem Statement:
   - The client is at risk for malnutrition due to inability to prepare her own meals secondary to congestive heart failure and shortness of breath.

   Goal:
   - The client will maintain ideal body weight of 130 pounds during the next 12 months as monitored during monthly contacts.

Interventions: Obtain oral nutritional supplements (ONS) (with prescription)
Arrange meals-on-wheels/home delivered meals
Coordinate nutrition consult (with prescription)
Provide adaptive utensils

Corrective Action:

The number of findings for care plans constituted trends and a CAP is required. The CAP for care plans will consist of submitting one care plan from each CM, along with the pertinent assessment/reassessment summary, and the functional needs assessment grids to CDA by September 1, 2010. The care plans need to incorporate TA provided during the exit conference and be written after June 23, 2010.

As the findings in Client Records #XXXX and #XXXX did not constitute trends, CDA does not intend to pursue recovery of funds. The site has discontinued the practice of purchasing XXXX for clients.

III. C Assessing and Documenting Client Risk

The goal of risk assessment is informed by the fact that MSSP clients have the right to refuse specific services and interventions. When a client refuses a service or intervention, the site must have a process of assuring that the risks associated with the refusal are addressed to the extent possible.

Assessing a client's ability to assume risk includes whether or not the client can:

- Make and communicate choices;
- Provide sensible reasons why choices were made;
- Understand the implications of choices; and
- Consider the consequences of choices.

A risk management plan will be developed when a situation arises where the client has chosen a course of action that may place the client at risk. This process allows for the systematic exploration of situations with a high possibility of an adverse outcome.

The status of the risk management plan must be monitored during regular monthly contacts by the CM. It must be formally reviewed or renewed at intervals mutually agreeable to the client and CM.

Reference: MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

III. D. Progress Notes

Progress notes are the ongoing chronology of the client's events and care management. They must address: health and safety issues; the provision of services as planned; whether services continue to be necessary and appropriate; whether they are being delivered as anticipated; and the client's response to the service. Notes shall include the following, as appropriate:

- The date and type of MSSP staff contact with the client;
- A record of all events that affect the client and the status or validity of the Care Plan;
- Actions taken when there are discrepancies between the Care Plan and services delivered;
- Any education or counseling support provided to either the client or caregiver;
- Evaluative subjective and/or objective comments on all services delivered and client outcomes in relation to needed services; and
- A reflection of the relationship between identified problems and services delivered or not delivered.

Progress notes must include any significant information regarding the client's relationship with family, community or any other information which would impact the established goals for the client's independent living.

Reference: MSSP Site Manual

Findings:

Two client records (#XXXX and #XXXX) contained documentation that quarterly home visits were conducted late. Client record #XXXX indicated that the home visit due XXXX XXXX was not conducted.

Five client records (#XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) did not address all care plan problems each month, including the month of reassessment. Two records (#XXXX and #XXXX) contained progress notes that listed problems the month of reassessment but did not describe the status of those problems.

Two client records (#XXXX and #XXXX) contained documentation of minimum contact by the CM. This type of documentation can be considered "social reassurance" by DHCS Audits & Investigations who can recover funding for the months with this type of progress notes.

Client Record #XXXX contained progress notes that were identical for the 13-month review period.

Client Record #XXXX contained progress notes that mixed up care plan numbers.

Client Record #XXXX contained progress notes that discussed a Problem #XX that was not found on the care plan

Recommendations:

Conduct a training session within 60 days of the date of this report to ensure all CMs understand requirements for documenting the status of all care plan problems and all care management activity including during months of reassessment. Submit to CDA the name of instructor, training materials used, and a list of attendees.

Incorporate the following TA into policies and procedures.

Technical Assistance

Review MSSP Site Manual Section3.820 What Progress Notes Include that states, "Progress notes are the ongoing chronology of the client's events and care management. They **must** address:

- health and safety issues;
- the provision of interventions as planned;
- whether interventions continue to be necessary;
- whether they are being delivered as anticipated; and
- the client's response to the interventions. (Section 3.640.6, Care Plan Monitoring).

Progress Notes must include the following:

- The date and type of MSSP staff contact with the client (whether the contact was a home visit or telephone call **must** be specified);
- A record of all events that affect the client (e.g., hospitalization, contact(s) with other agencies, problem statement retirement, falls, physician appointments, etc.);

- Progress notes **must** address and document each problem statement listed in the care plan;
- Actions taken when differences occur between the care plan and interventions;
- Any education or counseling provided to the client or caregiver to ensure that the needs of the client are met;
- The effectiveness of the interventions to address the needs described in the problem statements.
- Any significant information regarding the client's relationship with family, community or any other information which could impact the established goals for the client's independent living.

Corrective Action:

The number of findings constituted a trend; therefore, a CAP is required.

III. E. Case Record

MSSP sites must maintain up-to-date, centralized, confidential and secured case file records for each MSSP client, utilizing mandatory CDA forms. Sites are to implement case documentation, date and signature requirements, revisions and corrections according to the MSSP Site Manual specifications and time frames.

Case record documentation is a tangible part of the care management process which must be clear, timely, accurate, legible, appropriate and complete, providing the CM with working documents that are effective and efficient. The site shall also maintain and make available records for inspection and audit by the State.

Reference: MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. AUTHORIZATION AND UTILIZATION OF SERVICES

MSSP sites are responsible for maintaining complete records for funds received under the MSSP contract, including the tracking for purchased and referred services. Sites are required to cooperate with the State in the monitoring, assessment and evaluation of site processes. Sites must provide the CDA any relevant information requested through ad hoc reports that are related to administrative procedures.

The Department's Audit Branch will review the reconciliation process between service authorization and disbursement of payments to ascertain whether services authorized and provided were:

- Consistent with the Care Plan,
- Verified by the site, and
- Differences between authorized and verified services noted.

CDA MSSP staff will review selected client records to verify that correct procedures were followed in authorizing services for clients.

In authorizing services for a client, the CM will use the following prescribed order of priorities:

1. All services available through the informal support of family, friends, etc., must be used.

2. Existing Title XVIII Medicare, Title XIX Medi-Cal, Title XX Social Services, Title III Older Americans Acts, the Special Circumstances Program, and other publicly-funded services for which the client is eligible, and which are available in the community, must be relied upon, coordinated and recorded in developing a Care Plan. Within MSSP these services are called "Referred" services.

3. Only after the client's informal support and the existing public and private services are reviewed and optimally used, can the CM request the use of MSSP funds to purchase Waived Services. Within MSSP, these services are also called "Purchased" services.

CMs must be aware of the cost associated with maintaining a client in MSSP. When considering the acquisition of a piece of client equipment, e.g., emergency response device or non-medical home equipment, it is important to analyze both the purchase and rental options to determine the most cost-effective approach.

References: MSSP Site Manual and Contract

IV. A. Service Planning and Utilization Summary

The SPUS is an element of the client's Care Plan. The SPUS sets forth specific service information: who is the provider, what service is provided, how much it will cost, and what is the source of payment.

The SPUS is to be completed for each client for each month they are enrolled in the program. The services tracked on the SPUS are those purchased with waived services funds and certain categories of services obtained by referral to other funding sources.

The primary CM signs each client's verified SPUS each month. If the client's tracked costs are more than 95%, but less than 120%, of the site's benchmark, the Supervising CM must also sign; if costs exceed 120%, the Site Director must sign the SPUS, too.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. B. Tracking Cost Effectiveness

In addition to care management services provided by the MSSP site staff, the program is authorized to purchase supportive services from the list of approved Waived Services.

MSSP CMs are required to follow service authorization procedures which maximize the use of the informal support system and existing community service delivery systems (including use of the Medi-Cal Treatment Authorization Request [TAR] process) prior to the use of Waived Services.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. C. Vendor Agreement Review

Sites are responsible for arranging for the provision of client services. In addition to the MSSP Site Manual, there are two documents that must be consulted in this regard: the current MSSP Waiver and the individual site contract with CDA. Both the Waiver and the contract set forth policy and procedures which must be followed in structuring the terms and conditions of agreements with local service providers. In the contract, the site agrees to directly provide or arrange for the continuous availability and accessibility of all services identified in each client's care plan. In addition, the site agrees to maintain sufficient written vendor agreements for the following minimum array of Waived Services at all times.

(a) Adult Day Support Center (ADSC) and Adult Day Care (ADC)
(b) Housing Assistance
(c) Domestic Chore and Personal Care Services
(d) Care Management
(e) Respite Care
(f) Transportation
(g) Meal Services
(h) Protective Services
(i) Special Communications

Sites are required to maintain specific information and documents on each vendor of services. Sites must maintain copies of current license and insurance documents, and establish a tickler file or other system to ensure timely updating of this information. The Vendor Record Review Tool can assist sites with maintaining service provider compliance to MSSP requirements.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. QUALITY ASSURANCE ACTIVITIES

Quality assurance (QA) is characterized by a focus on systems, processes and outcomes, rewarding excellence, and working in a collaborative or partnership environment. It is ongoing, with each element continuously informing and supporting the entire process. Rather than replacing traditional program evaluation activities, quality assurance builds on and integrates them into an organized system.

MSSP sites are required to deliver quality services to clients through the continual demonstration of best practices in clinical care management. Sites will have a written policy describing their QA activities that includes a vision/mission statement, which ensures that staff fully support the mission and specifies the elements employed to secure this vision. QA elements include, but are not restricted to, a process of peer/internal review and a means to solicit client satisfaction with MSSP services.

V. A. Peer/Internal Review

Peer/Internal Review activities focus awareness on care management activities practiced within the program. Driven by the needs and abilities of the care management staff, this review process offers CMs an opportunity to learn from each other through the critical examination of professional practices.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. B. Client Satisfaction

Client Satisfaction Surveys, or other methods of obtaining information regarding client satisfaction, are instrumental to program operation analysis and the provision of quality client services.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. C. Home Visit

A home visit to a client ensures that clients are informed of their rights and receive quality services that meet their needs.

References: MSSP Site Manual and MSSP Contract

Home Visit Summary:

The CDA Nurse Evaluator and site SWCM made a home visit to Client #XXXX on XXXX XX, XXXX. The client was a XX-year old XXXX with medical diagnoses of XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX. The client was XXXX while sitting in the living room in XXX XXXX. The client's XXXX provided all information. The XXXX expressed XXX satisfaction with XXX care manager, MSSP, and services it provides. The XXXX stated XXX was aware of client rights and knew what actions to take should a disagreement arise. The XXXX is active in her XXXX and XXXX about XXXX that was XXXX in the XXXX XXXX edition of the XXXX XXXX XXXX.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

VI. BEST PRACTICES

Best Practices are those processes, policies, procedures and methods of casework that demonstrate exemplary work in the field of care management. Examples of Best Practices include, but are not limited to, administrative processes, the work done within an individual case, and general practices developed and applied to the work of all site care management staff.

The review team would like to acknowledge the site for the following examples of Best Practices that lead to improved client care:

1. CMs perform Geriatric Depression Scale Evaluations on all clients.

2. SWCMs and NCMs both sign reassessment summaries which validates collaboration between disciplines.

3. The site uses a color-coded system to prioritize the assistance clients would need during emergencies.

VII. SUMMARY

CDA plans to conduct a follow-up review approximately six months from the date of this report.

The site is acknowledged for its hospitality and for being receptive to the recommendations made and the TA provided during the UR process. This review team is available to provide continued technical support regarding the findings identified in this report.